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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07493

CERTIFICATE OF DEATH

07596

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - FOREST HILL</u> LENGTH OF STAY (in this place) <u>14 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - FOREST HILL</u> STREET ADDRESS (If rural give location) <u>WALTER'S MILL Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CONDIE KATHRYN AKERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 13 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 29, 1908</u>		9. AGE last birthday <u>49</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ALLEN J. NEWMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH BOWERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-26-5336</u>		17. INFORMANT & ADDRESS <u>WALTER B. AKERS (husband) FOREST HILL, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>UREMIA</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>COMPLETE RENAL FAILURE</u>						<u>5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA of CERVIX with metastases</u>						<u>2 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT.</u> , 19 <u>53</u> , to <u>JULY 13</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>JULY 13</u> , 19 <u>57</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stowers Jr.</u>				DATE SIGNED <u>JULY 13, 1957</u>			
ADDRESS (Street, city, town, state) <u>115 FULFORD AVE. BEL AIR</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JULY 16/57</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>BEL AIR Md.</u>	
24. REC'D BY REGISTRAR <u>Pravilla Lowwood</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul S. Stowers Jr.</u>		ADDRESS <u>Bel Air Md.</u>	
DATE <u>7-14-57</u>							

CERTIFICATE OF DEATH

REG. DEATH NO.

2. MEDICAL EXAMINER (PRINT OR TYPE NAME)

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO SCHOOL

DATE OF ENTRY INTO EMPLOY

DATE OF ENTRY INTO SERVICE

DATE OF ENTRY INTO OFFICE

DATE OF ENTRY INTO BUSINESS

DATE OF ENTRY INTO INDUSTRY

DATE OF ENTRY INTO AGRICULTURE

DATE OF ENTRY INTO FISHERY

DATE OF ENTRY INTO MINING

DATE OF ENTRY INTO MANUFACTURING

DATE OF ENTRY INTO TRANSPORTATION

DATE OF ENTRY INTO COMMUNICATIONS

DATE OF ENTRY INTO PUBLIC UTILITIES

DATE OF ENTRY INTO SOCIAL SERVICES

DATE OF ENTRY INTO HEALTH SERVICES

DATE OF ENTRY INTO EDUCATION

DATE OF ENTRY INTO RECREATION

DATE OF ENTRY INTO ARTS AND CRAFTS

DATE OF ENTRY INTO SCIENCE

DATE OF ENTRY INTO LITERATURE

DATE OF ENTRY INTO MUSIC

DATE OF ENTRY INTO THEATRE

DATE OF ENTRY INTO FILM

DATE OF ENTRY INTO RADIO

DATE OF ENTRY INTO TELEVISION

DATE OF ENTRY INTO COMMERCE

DATE OF ENTRY INTO INDUSTRY

DATE OF ENTRY INTO AGRICULTURE

DATE OF ENTRY INTO FISHERY

BUREAU V. 2

JUL 16 1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07494

07496

CERTIFICATE OF DEATH

Reg. Dist. No.

182-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>110 Fernway St</u>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>LEAN</u> Last <u>Ballard</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28th 1925</u>
9. AGE (In years) <u>32</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK AVERY</u>		14. MOTHER'S MAIDEN NAME <u>MASSIA SHADE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harry Ballard</u>		Address <u>Phila 21. Pa. 1713 Sycamore St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0</u> DUE TO <u>Acute Hemorrhagic Paracetitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4</u> , 19 <u>57</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>57</u> , and that death occurred at <u>12:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>600 S. Union Av.</u> DATE SIGNED <u>7/5/57</u> ACTUAL SIGNATURE <u>W.H. Sadowsky</u> M.D. PHYSICIAN'S NAME (Type) <u>W.H. SADOWSKY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/8/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bristol Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Borking</u>		24a. REC'D BY REGISTRAR DATE <u>7-9-57</u>	
ADDRESS <u>Aberdeen Md</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. S.

JUL 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07507 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07495

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>APG Station Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u> d. STREET ADDRESS <u>RDI</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Blesch</u> Last 4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1957</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-9-99</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Blesch</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Schfer</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215-18-7318</u>		17. INFORMANT <u>Ruth Riley (as in 2 above)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-9-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Nellie Perry</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For burial, cremation, or removal, file pages 1 and 2 with the registrar.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Date of Death: [illegible]
6. Place of Death: [illegible]
7. Cause of Death: [illegible]
8. Manner of Death: [illegible]
9. Signature of Medical Examiner: [illegible]
10. Date of Examination: [illegible]

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JUL 11 1957

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CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>		c. LENGTH OF STAY IN 1b <u>57 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>N-Breidenbaugh</u> Last <u>N-Breidenbaugh</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 17-1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Balto County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm. Henry Fehrman</u>				14. MOTHER'S MAIDEN NAME <u>Margareth Eckhart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-76-</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Archie Campbell, White Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobar Pneumonia</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 July</u> , 19 <u>57</u> , to <u>20 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 July</u> , 19 <u>57</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thos. A. E. Moseley Jr</u> M.D. <u>Jarrettsville, Md.</u> PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR., M.D. Jarrettsville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Ruff Jarrettsville Md</u>				24a. REC'D BY REGISTRAR <u>DATE 7-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Foxwood</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PLACE OF DEATH</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. CAUSE OF DEATH</p> <p>15. MANNER OF DEATH</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p> <p>21. SIGNATURE OF CLERGYMAN</p> <p>22. SIGNATURE OF JUDGE</p> <p>23. SIGNATURE OF SHERIFF</p> <p>24. SIGNATURE OF CORONER</p> <p>25. SIGNATURE OF JURY</p> <p>26. SIGNATURE OF COURT</p> <p>27. SIGNATURE OF STATE</p> <p>28. SIGNATURE OF NATION</p>	
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BUREAU V. 1

JUL 26 1957

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Item 18 Film 218 8-7-57
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 07509 07497
 Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RD 1	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDWARD Last BUNN, JR.		4. DATE OF DEATH Month July Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/49
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY child	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Edward Burr, Sr.		14. MOTHER'S MAIDEN NAME Cecelia Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs Cecelia Burr Aberdeen #140		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asthma DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerlin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerlin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY Union W. E. Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Varsing		ADDRESS Aberdeen Md.	
24. REC'D BY REGISTRAR July 23-57		24b. REGISTRAR'S SIGNATURE William P. Perry	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 25 1957
BUREAU V. 1

[Handwritten signature]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07510 CERTIFICATE OF DEATH

07499

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air-Rural-Kalma</u>		LENGTH OF STAY (in this place) <u>15 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air 32</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walter's Nursing Home Kalma, Md.</u>				STREET ADDRESS (If rural give location) <u>PENNSYLVANIA AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>Andrew George Chinaris</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 11, 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1858</u>	9. AGE last birthday <u>99</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metals Molder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>GREECE</u> ✓
13. FATHER'S NAME <u>George Chinaris</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Mrs. Geo. Chinaris, Bel Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>SENILITY AND ARTERIO-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>over 10 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>422.1</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 54</u> , 19 <u>54</u> , to <u>July 11, 1957</u> . That I last saw the deceased alive on <u>July 10, 57</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Neuman</u>		M.D. <u>307 Hickory, Bel Air, Md.</u>		DATE SIGNED <u>July 11, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 15, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>7.12.57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Sawood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Foster Funeral Home, Bel Air, Md.</u>	

CERTIFICATE OF DEATH

REG. ONE 182

1. PLACE, WHERE THE DECEASED RESIDED

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WARD OF BALTIMORE

STREET OF BALTIMORE

APARTMENT OF BALTIMORE

ROOM OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

RELIGION OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO STREET

DATE OF ENTRY INTO APARTMENT

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO DATE

DATE OF ENTRY INTO TIME

DATE OF ENTRY INTO CAUSE

DATE OF ENTRY INTO MANNER

DATE OF ENTRY INTO AGE

DATE OF ENTRY INTO SEX

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JUL 16 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07511

CERTIFICATE OF DEATH

Reg. Dist. No.

075001

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland New York b. COUNTY Harford Steuben			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Hornell 69X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 5025 Watervliet St (See birth cert.) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Roy Last Ciufo				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3 1957	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 1	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Leonard Richard Ciufo				14. MOTHER'S MAIDEN NAME Carol Jane Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Father		Address Same as in 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 July , 19 57 , to 4 July , 19 57 , that I last saw the deceased alive on 4 July , 19 57 , and that death occurred at 0145 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond M. Josen M.D.				ADDRESS (Street, city or town, state) US Army Hospital Aberdeen Proving Ground, Md DATE SIGNED 4 July 1957			
PHYSICIAN'S NAME (Type) RAYMOND M JOSEN Capt MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/1957		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Horning Aberdeen Maryland				24a. REC'D BY REGISTRAR DATE July 5-57		24b. REGISTRAR'S SIGNATURE Nellie R. Perry	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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JUL 8 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07512

CERTIFICATE OF DEATH

07501

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville x2 (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. STREET ADDRESS <u>Fallston Hill RD</u>			
3. NAME OF DECEASED (Type or print) <u>Eda Elizabeth Coe</u> First Middle Last				4. DATE OF DEATH <u>July 24</u> Month Day Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11 1915</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Balt Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Bachman</u>				14. MOTHER'S MAIDEN NAME <u>Annice Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William E. Coe Fallston, RD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR Pulmonale</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.3</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 June</u> , 19 <u>57</u> , to <u>24 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 July</u> , 19 <u>57</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. C. E. Mowley Jr</u>				DATE SIGNED <u>Jarrettsville Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martha E. Kunk</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>7.29.57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

JUL 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07513

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G217 7-16-57 et

07502

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whiteford</i>		c. LENGTH OF STAY IN 1b <i>x2 50ppn</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Farm John Wolf</i>		d. STREET ADDRESS <i>1 Mt. Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Alvin E Day</i>		4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>1937</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20 - 1895</i>
9. AGE (In years last birthday) <i>41</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Blowing Rock N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Thomas Day</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hodges</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-9073</i>	
17. INFORMANT <i>Thomas K Day</i>		Address <i>Benson Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> 912.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Crushing injury both chests</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Farm Tractor fell on him</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>7-8</i> a. m. <i>15</i> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Farm</i>		20f. (City or town) (County) (State) <i>Whiteford Harford Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Lerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 7/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mountain Christian</i>		22d. LOCATION (City, town, or county) (State) <i>Mountain Harford Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Lister</i>		24a. REC'D BY REGISTRAR <i>Prucilla Lowwood</i>	
		24b. REGISTRAR'S SIGNATURE <i>Prucilla Lowwood</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
M.D. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and markings on a form grid, including what appears to be a date 'JUL 8 1957' and various numbers.]

BUREAU V. S.

JUL 8 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7210 Harford Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ANTHONY</u> First <u>DEL MEDICO</u> Middle <u>DEL MEDICO</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP 14 1926</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary Lane</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gaetano Del Medico</u>		14. MOTHER'S MAIDEN NAME <u>ANNA LA PORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>353-12-2918</u>	
17. INFORMANT <u>Mrs Joan Del Medico</u> Address <u>1004 Evans Way</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND OF HEAD</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976x</u> DUE TO (c) <u>976x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>976x</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>SHOT SELF IN HEAD</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SHOT SELF IN HEAD</u>	
20c. TIME OF INJURY Month, Day, Year <u>1055</u> Hour <u>7-27</u> P. M. <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ROAD</u>	20f. (City or town) (County) (State) <u>BEL CAMP</u> <u>HARFORD</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		DATE SIGNED <u>7-28-57</u>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or MOVEMENT <u>BURIAL</u>	22b. DATE THEREOF <u>8-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u>		24a. REC'D BY REGISTRAR <u>PAUL</u>	24b. REGISTRAR'S SIGNATURE <u>Norman Moore</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

[Faint, mostly illegible handwritten text, possibly including names and dates.]

BUREAU V. 2

JUL 30 1957

RECEIVED

[Faint handwritten notes at the bottom of the page.]

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07504

07515 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford	MARYLAND	STATE Md.	COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural -> Bel Air	LENGTH OF STAY (in this place) 22 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Joppa	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Almshouse--Harford County		STREET ADDRESS (If rural give location) /	
3. NAME OF DECEASED (Type or Print) (First) IDA (Middle) M. (Last) FREY		4. DATE OF DEATH (Month) (Day) (Year) July 31 1957	
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH Nov. 5, 1875
9. AGE last birthday 81 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Harfor Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. McVey		14. MOTHER'S MAIDEN NAME Martha / ? Hoops	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Admission data--Almshouse			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Chr. Cardio-vascular disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 20, 1956 to July 31, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
SIGNATURE Willard P. Hudson		DATE SIGNED 7-31-57	
ADDRESS (Street, city, town, state) Forest Hill Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	
DATE THEREOF Aug. 3, 1957		LOCATION (City, town, or county) Abingdon Harford, Md.	
24. REC'D BY REGISTRAR AUG 5 1957		25. FUNERAL DIRECTOR'S SIGNATURE Howard R. Hudson	
REGISTRAR'S SIGNATURE Russella Howard		ADDRESS Abingdon Md.	

RECEIVED

NOTICE: This form is to be filled out by the attending physician or the coroner. It is to be filled out for all deaths, whether or not the death is due to natural causes. It is to be filled out for all deaths, whether or not the death is due to natural causes. It is to be filled out for all deaths, whether or not the death is due to natural causes.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

1. PLACE OF BIRTH		2. USUAL RESIDENCE (HOUSE OR BUSINESS)	
CITY		CITY	
COUNTY		COUNTY	
STATE		STATE	
DATE OF BIRTH		DATE OF DEATH	
TIME OF BIRTH		TIME OF DEATH	
HOURS		HOURS	
MINUTES		MINUTES	
SECOND		SECOND	
THIRD		THIRD	
FOURTH		FOURTH	
FIFTH		FIFTH	
SIXTH		SIXTH	
SEVENTH		SEVENTH	
EIGHTH		EIGHTH	
NINTH		NINTH	
TENTH		TENTH	
ELEVENTH		ELEVENTH	
TWELFTH		TWELFTH	
THIRTEENTH		THIRTEENTH	
FOURTEENTH		FOURTEENTH	
FIFTEENTH		FIFTEENTH	
SIXTEENTH		SIXTEENTH	
SEVENTEENTH		SEVENTEENTH	
EIGHTEENTH		EIGHTEENTH	
NINETEENTH		NINETEENTH	
TWENTIETH		TWENTIETH	
TWENTY-FIRST		TWENTY-FIRST	
TWENTY-SECOND		TWENTY-SECOND	
TWENTY-THIRD		TWENTY-THIRD	
TWENTY-FOURTH		TWENTY-FOURTH	
TWENTY-FIFTH		TWENTY-FIFTH	
TWENTY-SIXTH		TWENTY-SIXTH	
TWENTY-SEVENTH		TWENTY-SEVENTH	
TWENTY-EIGHTH		TWENTY-EIGHTH	
TWENTY-NINTH		TWENTY-NINTH	
THIRTIETH		THIRTIETH	
THIRTY-FIRST		THIRTY-FIRST	
THIRTY-SECOND		THIRTY-SECOND	
THIRTY-THIRD		THIRTY-THIRD	
THIRTY-FOURTH		THIRTY-FOURTH	
THIRTY-FIFTH		THIRTY-FIFTH	
THIRTY-SIXTH		THIRTY-SIXTH	
THIRTY-SEVENTH		THIRTY-SEVENTH	
THIRTY-EIGHTH		THIRTY-EIGHTH	
THIRTY-NINTH		THIRTY-NINTH	
FORTIETH		FORTIETH	
FORTY-FIRST		FORTY-FIRST	
FORTY-SECOND		FORTY-SECOND	
FORTY-THIRD		FORTY-THIRD	
FORTY-FOURTH		FORTY-FOURTH	
FORTY-FIFTH		FORTY-FIFTH	
FORTY-SIXTH		FORTY-SIXTH	
FORTY-SEVENTH		FORTY-SEVENTH	
FORTY-EIGHTH		FORTY-EIGHTH	
FORTY-NINTH		FORTY-NINTH	
FIFTIETH		FIFTIETH	
FIFTY-FIRST		FIFTY-FIRST	
FIFTY-SECOND		FIFTY-SECOND	
FIFTY-THIRD		FIFTY-THIRD	
FIFTY-FOURTH		FIFTY-FOURTH	
FIFTY-FIFTH		FIFTY-FIFTH	
FIFTY-SIXTH		FIFTY-SIXTH	
FIFTY-SEVENTH		FIFTY-SEVENTH	
FIFTY-EIGHTH		FIFTY-EIGHTH	
FIFTY-NINTH		FIFTY-NINTH	
SIXTIETH		SIXTIETH	
SIXTY-FIRST		SIXTY-FIRST	
SIXTY-SECOND		SIXTY-SECOND	
SIXTY-THIRD		SIXTY-THIRD	
SIXTY-FOURTH		SIXTY-FOURTH	
SIXTY-FIFTH		SIXTY-FIFTH	
SIXTY-SIXTH		SIXTY-SIXTH	
SIXTY-SEVENTH		SIXTY-SEVENTH	
SIXTY-EIGHTH		SIXTY-EIGHTH	
SIXTY-NINTH		SIXTY-NINTH	
SEVENTIETH		SEVENTIETH	
SEVENTY-FIRST		SEVENTY-FIRST	
SEVENTY-SECOND		SEVENTY-SECOND	
SEVENTY-THIRD		SEVENTY-THIRD	
SEVENTY-FOURTH		SEVENTY-FOURTH	
SEVENTY-FIFTH		SEVENTY-FIFTH	
SEVENTY-SIXTH		SEVENTY-SIXTH	
SEVENTY-SEVENTH		SEVENTY-SEVENTH	
SEVENTY-EIGHTH		SEVENTY-EIGHTH	
SEVENTY-NINTH		SEVENTY-NINTH	
EIGHTIETH		EIGHTIETH	
EIGHTY-FIRST		EIGHTY-FIRST	
EIGHTY-SECOND		EIGHTY-SECOND	
EIGHTY-THIRD		EIGHTY-THIRD	
EIGHTY-FOURTH		EIGHTY-FOURTH	
EIGHTY-FIFTH		EIGHTY-FIFTH	
EIGHTY-SIXTH		EIGHTY-SIXTH	
EIGHTY-SEVENTH		EIGHTY-SEVENTH	
EIGHTY-EIGHTH		EIGHTY-EIGHTH	
EIGHTY-NINTH		EIGHTY-NINTH	
NINETY		NINETY	
NINETY-FIRST		NINETY-FIRST	
NINETY-SECOND		NINETY-SECOND	
NINETY-THIRD		NINETY-THIRD	
NINETY-FOURTH		NINETY-FOURTH	
NINETY-FIFTH		NINETY-FIFTH	
NINETY-SIXTH		NINETY-SIXTH	
NINETY-SEVENTH		NINETY-SEVENTH	
NINETY-EIGHTH		NINETY-EIGHTH	
NINETY-NINTH		NINETY-NINTH	
HUNDRED		HUNDRED	

BUREAU V. 8

AUG 5 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAYRE de Grace			c. LENGTH OF STAY IN 1b Few hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES			4. DATE OF DEATH Month July Day 1 Year 1957		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-9-1915		9. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B.R.L. Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Proving Ground		11. BIRTHPLACE (State or foreign country) Aberdeen, Md.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles Green			14. MOTHER'S MAIDEN NAME Beatrice Octavia		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Charles Green - Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest. 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation.			
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p. m. 7/1 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Perryman Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/57	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-6-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Otelia J. Bullock - Hayre de Grace		ADDRESS Y. Ind.		24a. REC'D BY REGISTRAR DATE 7-6-57	24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07506

07498

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Perryman</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>RD # 1, Aberdeen</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Margaret</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 21, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John B. Nickle</u>			
14. MOTHER'S MAIDEN NAME <u>Hattie Trimble</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>S. Raymond Harris, Aberdeen, Md. R.N. 1.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Decomposition</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> (c) <u>Cerebral Apoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>334X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 23, 1957</u> to <u>July 27, 1957</u> , that I last saw the deceased alive on <u>July 27, 1957</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Simon</u> M.D.				ADDRESS (Street, city or town, state) <u>200 S. 2nd Avenue</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>E. J. Simon</u>				Name of home, etc. <u>Home of home, etc.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-30-1957</u>		<u>Principio</u>		<u>Principio Furnace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

See Page 112

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

See Page 112

1. Name of deceased: [blank]

2. Sex: [blank]

3. Age: [blank]

4. Date of birth: [blank]

5. Date of death: [blank]

6. Place of death: [blank]

7. Cause of death: [blank]

8. Signature of physician: [blank]

9. Signature of registrar: [blank]

10. Date of registration: [blank]

11. Name of registrar: [blank]

12. Name of hospital: [blank]

13. Name of attending physician: [blank]

14. Name of funeral home: [blank]

15. Name of undertaker: [blank]

16. Name of cemetery: [blank]

17. Name of place of burial: [blank]

18. Name of place of interment: [blank]

19. Name of place of cremation: [blank]

20. Name of place of entombment: [blank]

21. Name of place of inhumation: [blank]

22. Name of place of disposition: [blank]

23. Name of place of disposal: [blank]

24. Name of place of disposal: [blank]

25. Name of place of disposal: [blank]

26. Name of place of disposal: [blank]

27. Name of place of disposal: [blank]

28. Name of place of disposal: [blank]

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66. Name of place of disposal: [blank]

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68. Name of place of disposal: [blank]

69. Name of place of disposal: [blank]

70. Name of place of disposal: [blank]

71. Name of place of disposal: [blank]

72. Name of place of disposal: [blank]

73. Name of place of disposal: [blank]

74. Name of place of disposal: [blank]

75. Name of place of disposal: [blank]

76. Name of place of disposal: [blank]

77. Name of place of disposal: [blank]

78. Name of place of disposal: [blank]

79. Name of place of disposal: [blank]

80. Name of place of disposal: [blank]

81. Name of place of disposal: [blank]

82. Name of place of disposal: [blank]

83. Name of place of disposal: [blank]

84. Name of place of disposal: [blank]

85. Name of place of disposal: [blank]

86. Name of place of disposal: [blank]

87. Name of place of disposal: [blank]

88. Name of place of disposal: [blank]

89. Name of place of disposal: [blank]

90. Name of place of disposal: [blank]

91. Name of place of disposal: [blank]

92. Name of place of disposal: [blank]

93. Name of place of disposal: [blank]

94. Name of place of disposal: [blank]

95. Name of place of disposal: [blank]

96. Name of place of disposal: [blank]

97. Name of place of disposal: [blank]

98. Name of place of disposal: [blank]

99. Name of place of disposal: [blank]

100. Name of place of disposal: [blank]

BUREAU V. S.

AUG 2 1957

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07507

Reg. Dist. No.

180

07516

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	c. LENGTH OF STAY IN 1b 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.D. 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Phillip Middle Reed Last Jackson		4. DATE OF DEATH Month July Day 3 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 5, 1957
9. AGE (In years lost birthday) yrs. 4 Months 28 Days 8 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
13. FATHER'S NAME William E. Jackson		14. MOTHER'S MAIDEN NAME Eva Mullins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William E. Jackson		Address Joppa, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Hydrocephalus thru cribiform plate DUE TO 759.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGENITAL MALFORMATION at birth (c) Hydrocephalus; spinobifidus - meningorach INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis lower extremities from birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5 , 19 57 , to July 3 , 19 57 , that I last saw the deceased alive on July 2 , 19 57 , and that death occurred at 11:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip W. Heuman		ADDRESS (Street, city or town, state) 307 HICKORY, BEL AIR	
PHYSICIAN'S NAME (Type) Philip W. Heuman		DATE SIGNED July 3, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McKenna		24a. REC'D BY REGISTRAR July 6, 1957	
ADDRESS Abingdon Md		24b. REGISTRAR'S SIGNATURE Norma G. Moore	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07508

Reg. Dist. No. 185

07499

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. C.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidson</u> d. STREET ADDRESS <u>P. O. Box 221</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jackie</u> First <u>Johnson</u> Middle <u>—</u> Last <u>—</u> 4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1957</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1951</u> 9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Mooreville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE MAE DONALDSON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Juanita Sawyer - Bridge</u> Address <u>1159-229th Ave. North, Bridge, N.Y.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO <u>816x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-automobile</u>					
20c. TIME OF INJURY Month, Day, Year <u>7-20-57</u> Hour <u>6:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sussex Ave. Bridge Harve de Grace Md.</u>		20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford</u> <u>Bel Air</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>County</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>7-21-57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>7-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) <u>Davidson</u> (State) <u>N.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock-Harve de Grace, Md.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>7-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including handwritten notes and official stamps.]

RECEIVED
JUL 23 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07509

07517

Item 9 Film 0218 7/26/57 cap

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dartmouth</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Burley</u> Middle <u>Kegley</u> Last <u>Kegley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>11 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>10</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emmett Kegley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Creeger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-15-16-2927</u>	
17. INFORMANT <u>Mrs. Burley Kegley</u>		Address <u>Md. R. 10</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>430.1</u> (c), stating the underlying cause lost. (c) <u>430.1</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>430.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>7-18-57</u>	
ADDRESS <u>Baltimore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Pauline Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED
JUL 22 1957
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

07518

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lake Drive		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 0352.2	
3. NAME OF DECEASED (Type or print) GERTRUDE DORCAS MILLER		d. STREET ADDRESS 5570 Channing Road	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1894	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wrapper		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Mullineaux		14. MOTHER'S MAIDEN NAME Maranda E. Disney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 216-36-6174	
17. INFORMANT C. Edward Miller		Address Lake Drive-Belair Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 0 About 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 19 57 , to July 22, 19 57 , that I last saw the deceased alive on July 20, 19 57 , and that death occurred at 12:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 516 Cathedral Street DATE SIGNED 7/24/57	
ACTUAL SIGNATURE Ernest G. Marr M.D.		PHYSICIAN'S NAME (Type) Ernest G. Marr Baltimore 1, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. B. Wipbert		ADDRESS 1300 Eutaw Place	
24a. REC'D BY REGISTRAR Priscilla L. Loring		24b. REGISTRAR'S SIGNATURE Priscilla L. Loring	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
FUNDAMENTAL CAUSE		MORBIDITY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. 1

JUL 25 1957

RECEIVED

07500

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE				c. LENGTH OF STAY IN 1b 55 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 562 Revolution Street				d. STREET ADDRESS 562 Revolution Street			
3. NAME OF DECEASED (Type or print) First ELEANOR Middle Mitchell Last Mitchell				4. DATE OF DEATH Month 7 Day 22 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Denton, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev. George Mitchell-HAVRE de GRACE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) Hypertensive-Arteriosclerotic Heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8/11 , 19 50 , to 7/22 , 19 57 , that I last saw the deceased alive on 7/22 , 19 57 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 562 Revolution St., Havre de Grace, Md. DATE SIGNED 7/23/57 ACTUAL SIGNATURE George T. Stansbury PHYSICIAN'S NAME (Type) George T. Stansbury HAVRE de GRACE, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-1957		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Otelia S. Bullock - Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 7-23-57		24b. REGISTRAR'S SIGNATURE G. L. Kemio M.d.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF		19. SIGNATURE OF CONSTABLE		20. SIGNATURE OF JAILER		21. SIGNATURE OF WARDEN		22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF CHIEF OF POLICE		24. SIGNATURE OF CHIEF OF FIRE DEPARTMENT		25. SIGNATURE OF CHIEF OF PORT POLICE		26. SIGNATURE OF CHIEF OF MARINE POLICE		27. SIGNATURE OF CHIEF OF NAVY		28. SIGNATURE OF CHIEF OF AIR FORCE		29. SIGNATURE OF CHIEF OF COAST GUARD		30. SIGNATURE OF CHIEF OF CUSTOMS		31. SIGNATURE OF CHIEF OF REVENUE		32. SIGNATURE OF CHIEF OF EXCISE		33. SIGNATURE OF CHIEF OF STAMPS		34. SIGNATURE OF CHIEF OF POSTS		35. SIGNATURE OF CHIEF OF TELEGRAPHS		36. SIGNATURE OF CHIEF OF RAILWAYS		37. SIGNATURE OF CHIEF OF CANALS		38. SIGNATURE OF CHIEF OF BRIDGES		39. SIGNATURE OF CHIEF OF ROADS		40. SIGNATURE OF CHIEF OF PUBLIC WORKS		41. SIGNATURE OF CHIEF OF UTILITIES		42. SIGNATURE OF CHIEF OF SANITATION		43. SIGNATURE OF CHIEF OF HEALTH		44. SIGNATURE OF CHIEF OF EDUCATION		45. SIGNATURE OF CHIEF OF AGRICULTURE		46. SIGNATURE OF CHIEF OF COMMERCE		47. SIGNATURE OF CHIEF OF INDUSTRY		48. SIGNATURE OF CHIEF OF LABOR		49. SIGNATURE OF CHIEF OF SOCIAL WELFARE		50. SIGNATURE OF CHIEF OF CHARITIES		51. SIGNATURE OF CHIEF OF RELIGION		52. SIGNATURE OF CHIEF OF ARTS		53. SIGNATURE OF CHIEF OF LETTERS		54. SIGNATURE OF CHIEF OF SCIENCE		55. SIGNATURE OF CHIEF OF HISTORY		56. SIGNATURE OF CHIEF OF GEOGRAPHY		57. SIGNATURE OF CHIEF OF METEOROLOGY		58. SIGNATURE OF CHIEF OF ASTRONOMY		59. SIGNATURE OF CHIEF OF PHYSICS		60. SIGNATURE OF CHIEF OF CHEMISTRY		61. SIGNATURE OF CHIEF OF MEDICINE		62. SIGNATURE OF CHIEF OF SURGERY		63. SIGNATURE OF CHIEF OF DENTISTRY		64. SIGNATURE OF CHIEF OF VETERINARY MEDICINE		65. SIGNATURE OF CHIEF OF PHARMACY		66. SIGNATURE OF CHIEF OF NURSING		67. SIGNATURE OF CHIEF OF OPTIC		68. SIGNATURE OF CHIEF OF PODIATRY		69. SIGNATURE OF CHIEF OF MASSAGE		70. SIGNATURE OF CHIEF OF YOGA		71. SIGNATURE OF CHIEF OF MEDITATION		72. SIGNATURE OF CHIEF OF PSYCHIC		73. SIGNATURE OF CHIEF OF ESPERANTO		74. SIGNATURE OF CHIEF OF SANSKRIT		75. SIGNATURE OF CHIEF OF PERSIAN		76. SIGNATURE OF CHIEF OF ARABIC		77. SIGNATURE OF CHIEF OF HEBREW		78. SIGNATURE OF CHIEF OF GREEK		79. SIGNATURE OF CHIEF OF LATIN		80. SIGNATURE OF CHIEF OF ITALIAN		81. SIGNATURE OF CHIEF OF SPANISH		82. SIGNATURE OF CHIEF OF FRENCH		83. SIGNATURE OF CHIEF OF GERMAN		84. SIGNATURE OF CHIEF OF ENGLISH		85. SIGNATURE OF CHIEF OF SCOTCH		86. SIGNATURE OF CHIEF OF IRISH		87. SIGNATURE OF CHIEF OF WELSH		88. SIGNATURE OF CHIEF OF CYMRO		89. SIGNATURE OF CHIEF OF BRETON		90. SIGNATURE OF CHIEF OF NORMAN		91. SIGNATURE OF CHIEF OF NORMAN		92. SIGNATURE OF CHIEF OF NORMAN		93. SIGNATURE OF CHIEF OF NORMAN		94. SIGNATURE OF CHIEF OF NORMAN		95. SIGNATURE OF CHIEF OF NORMAN		96. SIGNATURE OF CHIEF OF NORMAN		97. SIGNATURE OF CHIEF OF NORMAN		98. SIGNATURE OF CHIEF OF NORMAN		99. SIGNATURE OF CHIEF OF NORMAN		100. SIGNATURE OF CHIEF OF NORMAN	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 03552	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 121 100 Marburth Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy Middle K. Last Owen		4. DATE OF DEATH Month July Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1916
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold Kidder		14. MOTHER'S MAIDEN NAME Bernice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Marshall D. Owen, 121 Marburth Ave., Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd and 3rd degree burns of 50% of body 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) Head injury (c) Auto-truck collision DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-truck collision	
20c. TIME OF INJURY Month, Day, Year 12:15 P. M. 7/16/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Conowingo (County) Harford (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) Parkville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR JUL 19 1957		24b. REGISTRAR'S SIGNATURE Dr. C. L. Lewis	

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HENNING		Male		45		1912		St. Louis, Mo.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
St. Louis, Mo.		Police Officer		Heart Disease		Natural		St. Louis, Mo.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
July 1, 1957		10:00 AM		St. Louis, Mo.		Natural		St. Louis, Mo.	
SIGNATURE OF MEDICAL EXAMINER		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS	
[Signature]		July 1, 1957		[Signature]		July 1, 1957		[Signature]	

BUREAU V. 1

JUL 19 1957

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July 1, 1957
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07513

CERTIFICATE OF DEATH

07502

Reg. Dist. No. 182

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>14 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>431 E Broadway</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>PAPACHRIST</u> (Last)				(Month) <u>July</u> (Day) <u>13</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>✓ ✓ 1898</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>US "Nat."</u>	
13. FATHER'S NAME <u>Arthur Papachrist</u>				14. MOTHER'S MAIDEN NAME <u>301e Papachrist</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-3073</u>		17. INFORMANT & ADDRESS <u>Mrs Sophia Papachrist 431 E Broadway Bel Air, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.1 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						<u>15 MIN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>CONGESTIVE HEART FAILURE</u>						<u>2 YEARS</u>	
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>							
19a. DATE OF OPERATION <u>260X</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>JULY 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 13</u> , 19 <u>57</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Neuman M.D.</u>				ADDRESS (Street, city, town, state) <u>307 Hickory, Bel Air, Md.</u>		DATE SIGNED <u>JULY 13, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>July 16/57</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) <u>Bel Air Md</u> (State) <u>Hartford</u>	
24. REC'D BY REGISTRAR <u>7.14.57</u>		REGISTRAR'S SIGNATURE <u>Prinella Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Ito</u>		ADDRESS <u>Bel Air Md</u>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. DATE OF DEATH

15. PLACE OF INTERMENT

16. NAME OF CEMETERY

17. NAME OF FUNERAL HOME

18. NAME OF NEXT OF KIN

19. ADDRESS OF NEXT OF KIN

20. TELEPHONE OF NEXT OF KIN

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JUL 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07514

07503

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OHIO STREET</u>				d. STREET ADDRESS <u>OHIO ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN FRANCIS STOUT</u>				4. DATE OF DEATH Month Day Year <u>JULY 14 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 17 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
13. FATHER'S NAME <u>HARRY STOUT</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>WALTER M. STOUT</u>				Address <u>HAVRE DE GRACE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest - Aspiration</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diffuse Cancer.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Gunther D. Hirsch</u> M.D. <u>7/15/1957</u> PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u> <u>HAVRE DE GRACE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JULY 17 1957</u>		<u>ANGEL HILL</u>		<u>HAVRE DE GRACE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Havre de Grace Md.</u>		24a. REC'D BY REGISTRAR <u>7-16-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>							

RECEIVED

JUL 17 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07515

07519 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Bel Air</u>		<u>4 (four)</u>		TOWN <u>Rural, Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emma</u> (Middle) <u>Ludema</u> (Last) <u>Sturgill</u>				(Month) <u>July</u> (Day) <u>31</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>January 5, 1873</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>House Wife</u>					<u>North Carolina</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Silas Montgomery Weiss</u>				<u>Ludema Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Roy N. Sturgill, Route #2, Bel Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>4-5-0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>July 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>57</u> , and that death occurred at <u>11:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>August 1, 1957</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Aug 4-57</u>		<u>Chestnut Hill</u>		<u>Crumpler, N.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>8-2-57</u>		<u>Purcella Louword</u>		<u>Kurtz Funeral Home, Jarrettsville</u>		<u>Trid.</u>	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07516

07520

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Iowa b. COUNTY Harford Polk	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Caroline Last Svensen		4. DATE OF DEATH Month July Day 19 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thorngren Svensen		14. MOTHER'S MAIDEN NAME Helen Frances Groesbeck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Father		Address (as in 2 above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (twin B) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776x (c) 776x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 9. Month July Day 19 Year 1957 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 , 19 57 , to July 19 , 19 57 , that I last saw the deceased alive on July 19 , 19 57 , and that death occurred at 900 a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED July 19 1957 ACTUAL SIGNATURE Earl W. Watts Jr. M.D. Aberdeen Proving Ground, Md PHYSICIAN'S NAME (Type) EARL W WATTS JR Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/57	
22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground Md	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tamm		24a. REC'D BY REGISTRAR July 23-57	
ADDRESS Aberdeen		24b. REGISTRAR'S SIGNATURE Hellie R Perry	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
William Thompson		Male		White		July 12 1887		Maryland		John Thomas		July 12 1957		John Thomas		Heart failure		Natural		John Thomas		John Thomas	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. County		19. Zip		20. Telephone		21. Signature of informant		22. Signature of registrar		23. Signature of physician		24. Signature of registrar	
John Thomas		Son		1234 Main St		Baltimore		Maryland		Baltimore		21201		234-5678		John Thomas		John Thomas		John Thomas		John Thomas	

RECEIVED
JUL 25 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07517

07521

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Iowa b. COUNTY Harford Polk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Edith Last Svensen				4. DATE OF DEATH Month July Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19 1957	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thorngren Svensen				14. MOTHER'S MAIDEN NAME Helen Frances Groesbeck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Father Address (as in 2 above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - twin A 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 , 19 57 , to July 19 , 19 57 , that I last saw the deceased alive on July 19 , 19 57 , and that death occurred at 805 a M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED July 19 1957 ACTUAL SIGNATURE William M. Michener M.D. Aberdeen Proving Ground, Md PHYSICIAN'S NAME (Type) WILLIAM M MICHENER Capt MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremated		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Rest Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground Md	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Lanning				ADDRESS Aberdeen		24a. REC'D BY REGISTRAR DATE July 23-57	
				24b. REGISTRAR'S SIGNATURE Hellie R Perry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2150211X40

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. JONES		35		M		W		1922		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1945		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MANAGER		1950		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1957		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1957		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
DATE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JULY 15 1957		1957		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
PLACE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
BALTIMORE		1957		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	
CITY OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
BALTIMORE		1957		BALTIMORE		BALTIMORE		BALTIMORE		JULY 15 1957		BALTIMORE		BALTIMORE	

William M. Williams

BUREAU VI B

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07518

CERTIFICATE OF DEATH

Reg. Dist. No.

181

07504

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>315 Edmund Street</i>		d. STREET ADDRESS <i>315 Edmund St</i>	
3. NAME OF DECEASED (Type or print) First <i>Lora</i> Middle <i>Elizabeth</i> Last <i>Sweeney</i>		4. DATE OF DEATH Month <i>7</i> Day <i>24</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/9/1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Edward Rogers</i>		14. MOTHER'S MAIDEN NAME <i>Corcelia W. Voght</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Kenneth Henry</i>		Address <i>315 Edmund St. Aberdeen Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>> 5 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>71 month</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 23</i> , 1957, to <i>July 24</i> , 1957, that I last saw the deceased alive on <i>July 24</i> , 1957, and that death occurred at <i>8:17 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>617 W. Belair Ave. 7-24-57</i>	
PHYSICIAN'S NAME (Type) <i>Aberdeen, Md.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>7/25/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Leicaku Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Leicaku Missouri</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Barringer</i>		ADDRESS <i>Aberdeen Maryland</i>	
24a. REC'D BY REGISTRAR <i>Thelie R. Perry</i>		24b. REGISTRAR'S SIGNATURE	
DATE <i>July 26-57</i>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

Age 1 month
2 days

Intermittent
fever

BUREAU V. S.

July 21 1957

15 W. 13th St. Boston, Mass. JUL 29 1957

Dr. J. J. Campbell

RECEIVED

July 21 1957

07522

CERTIFICATE OF DEATH

07519

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall				c. LENGTH OF STAY IN 1b 33 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Houcks Mill Rd (33rd LANE)			
3. NAME OF DECEASED (Type or print) First CARRIE Middle B. Last TITTLE				4. DATE OF DEATH Month JULY Day 13 Year 19-57			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1972	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Harford Co. Md	
13. FATHER'S NAME GILBERT				14. MOTHER'S MAIDEN NAME SARAH Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. -		17. INFORMANT Chas. Raymond Tittle Address White Hall Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peripheral-Vascular Disease (c) Arteriosclerotic-Hypertensive Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mos. 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 453.3 None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 1948 , to July 13 , 1957 , that I last saw the deceased alive on July 13 , 1957 , and that death occurred at 8:30 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. James Thompson Jr.				ADDRESS (Street, city or town, state) Jarrettsville, Maryland			
PHYSICIAN'S NAME (Type) S. James Thompson Jr.				DATE SIGNED 7/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16-57		22c. NAME OF CEMETERY OR CREMATORY Witts Joy		22d. LOCATION (City, town, or county) (State) Witts Joy Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Kutz				ADDRESS Jarrettsville		24a. REC'D BY REGISTRAR 7-18-57	
						24b. REGISTRAR'S SIGNATURE Priscilla Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamlet Chase Md.</u>				c. LENGTH OF STAY IN 1b <u>37 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>641 Otsego</u> <u>24</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Luzetta</u> Middle <u>Wallace</u> Last <u>Wilfong</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/20/1878</u> <u>79</u> yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Wilfong</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Lula J. Wilfong</u> Address <u>Hamlet Chase, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac DeCompensation</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-Vascular-Senal Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>p. m.</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan.</u> <u>1953</u> to <u>July</u> <u>1957</u> , that I last saw the deceased alive on <u>July 12</u> <u>1957</u> , and that death occurred at <u>10</u> <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>HAURA DE GRACE, MD</u> <u>7-23-57</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				<u>17AURA DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		22d. LOCATION (City, town, or county) (State) <u>Abundant Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hamlet Chase Md.</u>				24a. REC'D BY REGISTRAR <u>U. L. Lewis M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>U. L. Lewis M.D.</u>	

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